



STATE OF UTAH INSURANCE DEPARTMENT  
REPORT OF MARKET CONDUCT EXAMINATION  
of

**UNITED HEALTHCARE OF UTAH**  
7910 South 3500 East  
Salt Lake City, Utah 84121

NAIC Company Code Number: 95501

as of  
December 31, 1996

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November 6, 1997

The Honorable Merwin U. Stewart  
Insurance Commissioner  
Utah Insurance Department  
State Office Building, Room 3110  
Salt Lake City, Utah 84114

In accordance with your instructions, an examination has been made of the market conduct practices of

UNITED HEALTHCARE OF UTAH  
Salt Lake City, Utah

a domestic stock insurer, hereinafter referred to as the Company, as of December 31, 1996. The report of such examination is herein respectfully submitted.

## FOREWORD

The market conduct examination report is, in general, a report by exception. Reference to Company practices, procedures, or files subject to review may be omitted if no improprieties are encountered by the examiners.

## SCOPE OF EXAMINATION

This examination was conducted by examiners representing the Utah Insurance Department in accordance with the Model Market Conduct Examination Handbook of the National Association of Insurance Commissioners and Utah Code Annotated (U.C.A.) Chapter 31A-2, Administrations of the Insurance Laws. The period covered by the examination was September 1, 1992 to December 31, 1996. Where considered appropriate, transactions of the Company prior and subsequent to the examination period were reviewed.

The purpose of the examination was to determine the Company's compliance with U.C.A. Title 31A, and Rules promulgated by the Utah Insurance Department as contained in the Utah Administrative Code (U.A.C.) applicable to U.C.A. Title 31A, and to determine if Company operations were consistent with public interest.

## COMPANY PROFILE

### History

In 1983 a group of Salt Lake City physicians conducted research regarding the feasibility of organizing an independent health maintenance organization. This research led to the issuance, by the Office of Lieutenant Governor of the State of Utah in March 1984, of a Certificate of Incorporation for a health maintenance organization under the name of Physicians Health Plan of Utah. The Company negotiated a management contract with Charter Med, Inc. to provide the Company with a chief operating officer and marketing expertise. The Company was issued a Certificate of Authority by the Utah Insurance Department and commenced business during August 1984. Marketing began immediately and the first member enrollments were effective in October 1984.

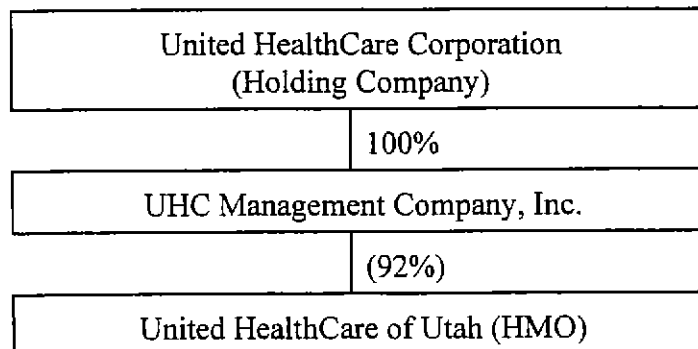
The Company was recognized as a federally qualified independent practice association model health maintenance organization in October 1985. Shortly thereafter, a subsidiary corporation, Physicians of Utah, was organized in order to maintain its authority to act as a state chartered health maintenance organization. This subsidiary was never activated and therefore, its certificate of authority was canceled in December 1990. Effective November 1991, the Company voluntarily relinquished its federal qualification.

In December 1986, Chartered Med, Inc. purchased a fifty-one percent majority interest in the Company. In October 1987, Chartered Med, Inc. changed its name to UHC Management Company, Inc. UHC Management Company, Inc. is a wholly owned subsidiary of United HealthCare Corporation, who owns and manages a national network of health maintenance organizations. By January 1991, UHC Management Company, Inc., through a tender offer, had increased its equity interest in the Company to approximately eighty-five percent. In July 1992, the Company's Articles of Incorporation was amended to change the name of the Company from Physicians Health Plan of Utah to United HealthCare of Utah. In December 1994, UHC Management Company, Inc. further increased its ownership in the Company to approximately ninety-two percent. On January 1, 1997, UHC Management Company, Inc. changed its name to United HealthCare Services, Inc.

Effective May 1, 1994, the Company entered into a contract with the Utah Department of Health, Division of Health Care Financing to provide Medicaid services.

### **Affiliated Companies**

The Company is a member of an insurance holding company system and the ultimate controlling entity within that system is United HealthCare Corporation. United HealthCare Corporation is a publicly held developer and marketer of alternative health care delivery systems and related products and services. The following chart depicts the ownership of the Company as of December 31, 1996.



The Company entered into a Management Agreement with its immediate parent, UHC Management Company, Inc. during January 1993. Under this agreement, the parent provided many of the services necessary for the Company's operation, including general administrative and financial services, claims processing, underwriting services, internal audit services, legal services, marketing and sales support, membership services, staffing services and supervision, retention of office space, furniture and equipment, and payments related to consultants or third party advisors. Subsequent to the examination date, an amendment to the Management Agreement regarding post-termination claims services was executed by the Company and its immediate parent in June 1997.

### **Territory and Plan of Operations**

The Company has a Certificate of Authority authorizing it to conduct business as a health maintenance organization in the State of Utah. As of December 31, 1996 the Company had contracts with 1,819 providers, including 276 pharmacies, including 1,530 independent physicians, 13 hospitals, and other health care providers to deliver health care services to its members in Box Elder, Davis, Morgan, Salt Lake, Summit, Tooele, Utah, Wasatch, and Weber Counties. The Company utilizes not only its own provider network, but also contracts with Talbert Medical Group and University of Utah.

The Company is a non-federally qualified independent physicians association (IPA) model health maintenance organization and is a for-profit corporation. Reimbursements to providers are done on a modified fee-for service and capitated basis.

New and renewal business is solicited primarily by outside independent agents, agencies and general agents. Company Account Executives are assigned to train and work with the outside producers servicing the Company's group products to ensure the producers better understand the Company and its products in order to increase the Company's market share. In a few cases, an employer group works directly with the Company, rather than through outside agents. The Company does not use managing general agents as part of its agency force.

The Company targets groups having one hundred or more employees; however, it will accept groups with as few as two enrollees. Individual contracts had not been offered since 1987, until the Company again began underwriting individual contracts in mid-1996. In April 1997 the Company again ceased from offering individual contracts. Company enrollment as of the December 31, 1996 examination date comprised of the following:

Classification	Member Enrollees
Groups	97,012
Medicaid	15,830
Individual	609
Total	113,451

The Company advertises through various mediums, including newspapers, magazines, billboards, point of sale brochures and flyers, and limited national television coverage.

### Company Growth

The table below reports the Company's growth in membership and premium for the last six years. Numbers were taken from the Company's filed annual statements.

Year	Year End Member Enrollment	Year End Premium & Related Revenue
1996	113,451	\$126,118,783
1995	100,650	102,958,359
1994	82,477	83,789,856
1993	71,008	64,957,488
1992	51,001	46,867,622

## **PREVIOUS EXAMINATION FINDINGS**

The previous market conduct examination report as of August 31, 1992, and financial examination report as of December 31, 1995, issued by the Utah Insurance Department were reviewed. Company correspondence as to the findings and recommendations of the market conduct examination report was also reviewed. The Company stated in the correspondence that steps would be taken to "address each recommendation noted in the report to meet the standards established by the Utah Code." The Company did not specify what follow-up actually occurred as related to the specific findings and recommendations identified in the report.

One of the recommendations in the market conduct examination report as of August 31, 1992 was that the four "cited provisions of Chapter 8, Title 31A, and Utah Insurance Rule R590-76 be complied with". Three of the four cited provisions referred to in that recommendation were not complied with, as identified in the HMO Specific Requirements section of this current report.

## **CURRENT EXAMINATION FINDINGS**

### **Company Operations/Management**

#### **General**

Company records were generally adequate, consistent and orderly and were in compliance with the Utah insurance laws and rules, except as otherwise noted in this report.

#### **Certificate of Authority**

The Company's Certificate of Authority was reviewed and found to be current. The Company is licensed for the line of business being written and is operating within the parameters of its Certificate of Authority.

#### **Internal/External Audits**

United HealthCare Corporation has an internal audit program in place. The corporate internal control practices and specific application and operating system controls are examined on a regular basis by its Internal Audit Department. This includes tests of data of United HealthCare of Utah. In addition, external audits are performed annually which provide meaningful information to management. Compliance with policies and procedures is monitored by Internal Audit as a part of their routine reviews. Audit findings and recommendations are communicated to management, as well as senior executives and the Board of Directors.

#### **Anti-Fraud Plan**

United HealthCare Corporation has a written anti-fraud plan in place, applicable to the Company. The computer system used by the Company has several fraud prevention and detection techniques installed.

### **Disaster Recovery Plan**

United HealthCare Corporation has a written disaster recovery plan which provides for the recovery of critical applications residing on the mainframe systems and detailing procedures for continuing business operations in the event of a disaster. This plan is updated as needed to reflect changes in the corporation's environment. The corporation has sent a "Business Continuation Plan" to the Company to use as a guideline in establishing and implementing its own local Business Continuation Plan. The Company is currently in the process of formalizing in writing its own in-house version of this plan.

### **Computer Information/Data Security**

The Company's computer information/data security systems were reviewed. The Company adequately provides for off-site backup storage and recovery and has appropriate controls, safeguards and procedures in place for protecting the integrity of computer information.

### **Complaint Handling**

The Company has written complaint/grievance procedures in place. Grievances are classified in two broad categories; Plan Administration and Benefits Denial. Grievances are received by any Company department and routed to the plan administrator who is to acknowledge receipt of the grievance within ten days. Complaints filed with the Utah Insurance Department are also logged by the plan administrator and processed within required time-lines. The grievance is entered into a tracking log and assigned to the appropriate department to be researched and handled. If the grievance cannot be resolved there it may be brought before the management level Grievance Committee, who confirms the results to the complainant within thirty days from receipt of the grievance. If still no resolution, the complainant may appear before a Complaint Review Panel, which will notify the complainant of its decision within fourteen days by certified mail.

The Company's consumer complaint register was reviewed. Six hundred sixteen grievances were received by the Company during 1995 and 1996, including eighteen complaints filed with the Utah Insurance Department. A sample of sixty five grievance files were reviewed, including all eighteen of those filed with the Utah Insurance Department.

Written Company procedures require resolution of the complaint within thirty days of receipt for complaints that do not advance to the Grievance Committee level. Four of the complaints reviewed were not resolved within the required thirty day period. Two of those were delayed due to requested medical information the Company was waiting for as part of the investigation.

The received date for complaints received by the Company was sometimes difficult to determine due to inadequate file documentation. Company procedure is to date stamp the envelope as mail is received by the Company. However, in some cases the date-stamped envelopes became detached from the contents and the received date was unable to be determined.

## **Marketing and Sales**

The Company advertises through various mediums, including newspapers, magazines, billboards, point of sale brochures and flyers, and limited national television coverage. All Company advertising is generated and controlled through the corporate office. Company products are marketed to prospective purchasers primarily through outside independent agents, agencies and general agents.

Company marketing and sales materials were reviewed, including its 1996 Sales and Marketing Plan, written procedure guidelines, informational booklets, employer proposal packets and employee enrollment packets used by the Company's producers, advertisements, sales brochures and flyers, application and enrollment forms, policy benefit summaries and other materials. Discrepancies noted as a result of this review are disclosed in the following two paragraphs.

The application form used by the Company in marketing its "United Health One" policy to individuals during the examination period did not include a question to elicit information as to whether the insurance to be issued was intended to replace any other disability policy or certificate in force. Failure to include such a question in the application form is a violation of U.A.C. Subsection R590-126-9.A.

An endorsement of a Company employee was used in a Company advertisement without disclosing the fact of the representative capacity of the employee in the advertisement. Failure to disclose the representative capacity of the employee in the advertisement is a violation of U.A.C. Subsection R590-130-9.B.

## **Producer Relationships**

The Company utilizes independent agencies and agents to market its products. It does not utilize managing general agencies, general agencies or third party administrators. The Company provided a list of the producers currently contracted and appointed by the Company. This list was compared with the Utah Insurance Department list of producers appointed with the Company. In connection with this comparison, also reviewed were the Company's producer contract files, producer contract language, effective dates of business produced and Company commissions paid to producers and other information. The following discrepancies were noted as a result of this comparison and review

Six agencies were contracted with the Company and listed on Company records as being appointed with the Company, although a Certificate of Appointment was not on file with the Utah Insurance Department. Three of those agencies had previously been contracted and appointed with the Company, but the contracts and appointments had been terminated due to lapsed licenses. However, the Company continued to list the agencies as appointed and failed to re-appoint the agencies and reinstate the agency contracts. In one case, the agency had changed

its name and allowed the license under the old name to lapse. The license was later reinstated under the new name. Although the license had lapsed, the Company continued to show the agency as appointed and the Company never re-appointed the agency nor reinstated the agency contract under the new name. Five agents were licensed and contracted with the Company under one name, but referred to on some Company records under a different name. One agency was contracted and paid commissions under the agency name, but appointed under a separate individual name. In two cases, agents produced business for the Company and were paid commissions when no contract or appointment was in place. During a review of underwriting files, five cases were found in which business was produced for the Company prior to being appointed by the Company. Failure to file a Certificate of Appointment with the Utah Insurance Department is a violation of U.A.C. Section R590-101-4. Failure to appoint an agent prior to the agent doing business for the Company is a violation of U.C.A Subsection 31A-23-219(1). Representing a Company without an appointment and a written agency contract is a violation of U.C.A. Section 31A-23-309. Utilizing the services of another as an agent when the Company knows or should know the other does not have a license is a violation of U.C.A. Section 31A-23-201. Compensating a person for services performed as an agent, when the Company knows or should know the payee is not licensed, is a violation of U.C.A. Subsection 31A-23-404(1).

The producer contracts require broker licenses, rather than agent licenses. However, in actual practice, most of the producers are licensed as agents and act in the capacity of agents, not brokers. Company policies and procedures manuals were requested for review. The Company does not have a policies and procedures manual covering the area of producer relationships.

### **Underwriting/Rating**

#### **General**

Health Insurance benefits are provided by the Company to small employer groups as well as large employer groups. Individual subscribers and their dependents within the small groups are currently medically underwritten on an individual basis through a health statement supplied by the Company. Large groups are not medically written on an individual basis. During 1996, the Company began underwriting individual policies for a limited time, until April 1997, when the Company ceased from offering individual policies. The underwriting function is primarily handled by the United HealthCare Corporation underwriting staff in Minneapolis, Minnesota.

The Company utilized a "percent of premium" basis during the examination period for reviewing health risks, referring to medical books and physicians to assist in determining potential treatments, the cost of these treatments and definitions of conditions. Small groups of 2 to 24 employees were "table rated," using adjusted community rating methodology and tables. The groups were generally either approved or denied as submitted, based on whether the expected premium to be generated by the group would sufficiently cover the estimate of the groups ongoing conditions and claims. As a general rule, the group would be denied when the Company's analysis determined claims by one-third of the members were expected to utilize two-thirds of the groups premium.

For small groups of 25 to 49 employees, an "Employer Form" was often completed by the group administrator and submitted to the Company rather than the "Under 50 Group Application" form. In these cases, the information on the "Employer Form" was generally the only health history received by the Company for the group. These groups were "factor rated", using a single, employee + child(ren), employee + spouse, and family basis. Rating of the group was also affected by industry information, competitive data and/or claims data, when available. If the information showed a group to be a "better than average" risk, the premium could be reduced. The maximum any group of 2 through 49 employees could be "rated up" was a 1.2 rate factor.

Large groups of 50 plus employees submitted an "Employer Form" for review by the underwriting department. When available, the group's past claims information was used to establish the proposed premium levels. Rates for large groups were quoted on either a "composite" basis of single/family, single/two party, and family, or on a single, employee + child(ren), employee + spouse, and family basis.

#### **Review of Forms and Required Filings**

The Company's rates and rate filings are developed and filed through United HealthCare Corporation. The Company's forms are also developed by the corporate office, although the form filings are filed and maintained locally by the Company's Sales Administration Division. The Company does not have written procedures pertaining to the filing of forms.

The Company's rating manual and "Under 50 Group Application" form refers to small employer groups as those with "fewer than 50 eligible employees", and large group application forms refer to large employer groups as those with "50+" employees. However, according to U.C.A. Section 31A-30-103, an employer with 50 eligible employees is defined as a "small employer".

The conversion provision language of the Company's "11/92 United HealthCare of Utah Certificate" form requires application and payment of the initial premium to be made within 31 days after termination of coverage under the policy. However, U.C.A. Subsection 31A-22-704(1) allows 60 days after termination of coverage for application and payment.

The conversion provision language of United Health and Life Insurance Company's certificate of coverage form, which the Company used in conjunction with its own products and distributed to its members, requires application and payment of the initial premium to be made within 30 days after termination of coverage under the policy. However, U.C.A. Subsection 31A-22-704(1) allows 60 days after termination of coverage for application and payment.

United Health and Life Insurance Company's certificate of coverage form, which the Company used in conjunction with its own products and distributed to its members, defines a preexisting condition more restrictively than allowed under U.C.A. Subsection 31A-30-107(4).

### Underwriting File Review

Underwriting files for group business issued, terminated or declined by the Company between January 1, 1994 and December 31, 1996 were reviewed. The sample selected and reviewed in each of these categories are shown in the following table.

Category	Sample Selected and Reviewed
Issued Business	52
Terminated Business	20
Declined Business	15
Combined Totals	87

In fourteen of the underwriting files reviewed, a group policy form had been used by the Company which had not been filed with the Utah Insurance Department. This is a violation of U.C.A. Subsection 31A-21-201(1).

Several of the underwriting files reviewed were not adequately documented. In eight cases, the application was incomplete as the signature of the agent was missing. In two cases, the group contract was not dated. In ten cases involving small groups of under twenty-five employees, no health history form was in the file. In one case, the group contract and schedule of benefits forms was missing. In seven cases, the Company failed to retain a signed statement from the small employer that the Company offered to accept all eligible employees and their dependents at the same level of benefits under the health benefit plan provided to the employer. Failure to retain a statement to that effect is a violation of U.A.C. Subsection R590-176-5.A.1.

In addition to the above underwriting file review, a separate review was performed on the fifty-one small employer group applications declined by the Company during 1996 prior to submitting its June 19, 1996 certification to the commissioner that the Company's open enrollment cap had been met. The purpose of this review was to determine whether the Company was in compliance with U.C.A. Chapter 31A-30, Individual and Small Employer Health Insurance Act, and U.A.C. Rule R590-176, Small Employer Open Enrollment Rule. Three of the applications declined were eligible for open enrollment under this rule. Declining open enrollment prior to submitting certification to the commissioner that the open enrollment cap had been met was a violation of U.A.C. Subsection R590-176-8.A. By declining the applications, the Company selectively or unfairly delayed, obstructed or otherwise hindered the applicants from obtaining coverage under U.C.A. Chapter 31A-30. This was a violation of U.A.C. Subsection R590-176-4.A and U.C.A. Subsection 31A-30-108(1).

## **Policyholder Service**

Seventy-two policyholder files were reviewed with regard to policyholder service and treatment, including a review of notices, billings, delays, timely response, premium administration and refunds, coverages, endorsements, cancellations and reinstatements. Policyholder service was generally timely and correct. No discrepancies related to policyholder service were encountered, other than those already listed in other sections of this report.

## **Claims**

### **General**

The Company's hospital and physician claims are processed through the corporate process centers in Duluth or International Falls, MN. Mental health and pharmacy claims are processed directly by the insurers providing mental health services and pharmacy services to the Company's membership. Claims processed through the corporate centers can initially be entered either on-line at the Company, via tapes or files sent from service bureaus, or electronically by the provider via ProviderLink®. Access to application data and processing screens is controlled by security software regardless of the medium used to enter the claim.

Upon entry into the system, claims are validated against major review criteria, such as coordination of benefits, duplicate billings, non-covered services, etc. The claims are then either paid based on built in edits, or highlighted for various conditions requiring further review. The calculation process examines the current on-line contract information, and pays accordingly. Claims pended for further processing are reported on exception and error reports and sent to the appropriate processor for follow-up and resolution. Claims pending review are cleared by the processor after analyzing all relevant information.

The system has several control features such as denial and disapproval logic, automated calculations, and automatic review for multiple fee schedule capability. In addition, physician claims are adjudicated through AdjudiPro, an expert system that emulates procedures and thought processes used by humans to do certain tasks. The Company retains on-line computer access to claims processed at the corporate process centers. Each time a claim is accessed by the on-line program it is checked by the edit/review process.

Quality Assurance performs quality reviews on claims processing. For 2-3% of claims paid, data input to the system is compared to claim documentation and all calculations are verified. Higher percentages of claims may be reviewed for individual processors, based on the processor's performance history. Newly hired processors are subject to a 100% review of their work during the first three months.

The following chart reflects the dollar amount of claims paid by the Company during the examination period.

<u>Paid Claims in Dollars</u>	
1992	37,289,579
1993	52,636,344
1994	68,366,541
1995	86,537,932
1996	108,549,383
(The figures shown were taken from the Company's December 31, 1996 filed annual statement, page 30)	

#### **Claim File Review**

A random sample of fifty-eight claim files for the years 1994, 1995 and 1996 were selected for review. Some of the files contained multiple claims, resulting in a total of seventy-three claims reviewed. Computer data for all seventy-three claims was reviewed. The hard copy backup of twenty-two of these claims, selected on a systematic interval basis, was also reviewed.

U.A.C. Subsection R590-89-10(A), requires acknowledgment of claims not settled within fifteen days of receiving notification of the claim. At least sixteen of the claims reviewed did not meet this requirement. No other discrepancies were noted as a result of the claim file review.

#### **HMO Specific Requirements**

##### **General**

In addition to the general regulatory requirements for insurers, health maintenance organizations have other specific regulatory requirements to comply with. The additional market conduct requirements are found in U.C.A. Chapter 31A-8, Health Maintenance Organizations and Limited Health Plans, and in U.A.C. Rule R590-76, Health Maintenance Organizations.

Company operations were reviewed with regard to these additional specific regulatory requirements, including a review of provider relations materials, provider contract language, provider credentialing, provider malpractice insurance requirements, provider quality control procedures and provider complaint procedures.

The Company did not prepare certified annual reports of the effectiveness of the organization's internal quality control, as required by U.C.A. Chapter 31A-8. The Company was informed of this requirement in its prior market conduct examination report as of August 31, 1992 by the Utah Insurance Department. Although the format for the report has not been specified by the Insurance Commissioner, lack of a prescribed format does not negate the organization's requirement to prepare the report. Failure to prepare the annual reports is a violation of U.C.A. Section 31A-8-404.

The Company has developed a quality assurance plan, however the plan has not been certified, as required by U.A.C. Rule R590-76. The Company was informed of this requirement in its prior market conduct examination report as of August 31, 1992 by the Utah Insurance Department. Failure to arrange and pay for a review and certification of its quality assurance plan is a violation of U.A.C. Subsection R590-76-10.B.1.

#### **Provider File Review**

Provider lists were supplied by the company from which sixty-six provider contract files of health service providers, hospitals, physicians and practitioners were selected and reviewed. Discrepancies noted as a result of the review are disclosed in the following paragraph.

Several provider contract files had missing or incomplete information, as follows. In four cases, the files contained signed and dated appendums but no signed provider contracts. In two files, the execution date of the provider contract was not completed by provider. Five files did not contain evidence of professional liability insurance for the providers, as required by U.A.C. Rule R590-76, although the Company was informed of this requirement in its prior market conduct examination report as of August 31, 1992 by the Utah Insurance Department. Failure to show evidence of professional liability insurance is violation of U.A.C. Subsection R590-76-12 (F).

### **SUMMARIZATION**

#### **Summary**

Comments included in this report which are considered to be significant and requiring special attention are summarized below:

1. Written Company procedures require resolution of the complaint within thirty days of receipt for complaints that do not advance to the Grievance Committee level. Four of the complaints reviewed were not resolved within the required thirty day period, although two of those were delayed due to requested medical information the Company was waiting for as part of the investigation. The examiner recommends the Company review and/or implement quality control measures to ensure compliance with Company's own written procedural requirements.  
**(COMPLAINT HANDLING)**

2. The received date for complaints received by the Company was sometimes difficult to determine due to inadequate file documentation. Company procedure is to date stamp the envelope as mail is received by the Company. However, in some cases the date-stamped envelopes became detached from the correspondence and the received date was unable to be determined. The examiner recommends the Company review and/or implement quality control measures to ensure the received date of the complaints can be readily determined.

**(COMPLAINT HANDLING)**

3. The application form used by the Company in marketing its "United Health One" policy to individuals during the examination period did not include a question to elicit information as to whether the insurance to be issued was intended to replace any other disability policy or certificate in force. Failure to include such a question in the application form is a violation of U.A.C. Subsection R590-126-9.A. The examiner recommends the Company review and/or implement quality control procedures to ensure compliance with this rule. **(MARKETING AND SALES)**

4. An endorsement of a Company employee was used in a Company advertisement without disclosing the fact of the representative capacity of the employee in the advertisement. Failure to disclose the representative capacity of the employee in the advertisement is a violation of U.A.C. Subsection R590-130-9.B. The examiner recommends the Company correct the advertisement to comply with this rule. **(MARKETING AND SALES)**

5. Six agencies were contracted with the Company and listed on Company records as being appointed with the Company, although a Certificate of Appointment was not on file with the Utah Insurance Department. Three of those agencies had previously been contracted and appointed with the Company, but the contracts and appointments had been terminated due to lapsed licenses. However, the Company continued to list the agencies as appointed and failed to re-appoint the agencies and reinstate the agency contracts. In one case, the agency had changed its name and allowed the license under the old name to lapse. The license was later reinstated under the new name. Although the license had lapsed, the Company continued to show the agency as appointed and the Company never re-appointed the agency nor reinstated the agency contract under the new name. Five agents were licensed and contracted with the Company under one name, but referred to on some Company records under a different name. One agency was contracted and paid commissions under the agency name, but appointed under a separate individual name. In two cases, agents produced business for the Company and were paid commissions when no contract or appointment was in place. During a review of underwriting files, five cases were found in which business was produced for the Company prior to being appointed by the Company. Failure to file a Certificate of Appointment with the Utah Insurance Department is a violation of U.A.C. Section R590-101-4. Failure to appoint an agent prior to the agent doing business for the Company is a violation of U.C.A Subsection 31A-23-219(1). Representing a Company without an appointment and a written agency contract is a violation of

U.C.A. Section 31A-23-309. Utilizing the services of another as an agent when the Company knows or should know the other does not have a license is a violation of U.C.A. Section 31A-23-201. Compensating a person for services performed as an agent, when the Company knows or should know the payee is not licensed, is a violation of U.C.A. Subsection 31A-23-404(1). The examiner recommends procedures be implemented or changed to ensure, in all cases, producers are properly licensed, appointed and contracted prior to doing business for the Company or being compensated by the Company, and all appointments are properly filed with the Utah Insurance Department. **(PRODUCER RELATIONSHIPS)**

6. The producer contracts require broker licenses, rather than agent licenses. However, in actual practice, most of the producers are licensed as agents and act in the capacity of agents, not brokers. The examiner recommends the producer contracts be amended to require the producers to have an agent license if the producer will be acting in the capacity of an agent. **(PRODUCER RELATIONSHIPS)**.

7. The Company's rating manual and "Under 50 Group Application" form refers to small employer groups as those with "fewer than 50 eligible employees", and large group application forms refer to large employer groups as those with "50+" employees. However, according to U.C.A. Section 31A-30-103, an employer with 50 eligible employees is defined as a "small employer". The examiner recommends the Company amend the language in the rating manual and application forms to reflect the group size as defined in this statute. **(UNDERWRITING/RATING)**

8. United Health and Life Insurance Company's certificate of coverage form is used by the Company in conjunction with its own products and is distributed to its members. The conversion provision language of this form requires application and payment of the initial premium to be made within 30 days after termination of coverage under the policy. Additionally, the conversion provision language of the Company's "11/92 United HealthCare of Utah Certificate" form requires application and payment of the initial premium to be made within 31 days after termination of coverage under the policy. However, U.C.A. Subsection 31A-22-704(1) allows 60 days after termination of coverage for application and payment. The examiner recommends the language in policy forms be amended to allow at least 60 days for application and payment after termination of coverage. **UNDERWRITING/RATING)**

9. United Health and Life Insurance Company's certificate of coverage form, which was used in conjunction with Company products and distributed by the Company to its members, defines a preexisting condition more restrictively than allowed under U.C.A. Subsection 31A-30-107(4). The examiner recommends the preexisting condition definition of the policy form be amended to comply with this statute. **UNDERWRITING/RATING)**

10. In fourteen of the underwriting files reviewed, a group policy form had been used by the Company which had not been filed with the Utah Insurance Department. This is a violation of U.C.A. Subsection 31A-21-201(1). The examiner recommends the Company review and/or implement quality control procedures to ensure all forms are properly filed in accordance with statutory requirements. **(UNDERWRITING/RATING)**

11. Several of the underwriting files reviewed were not adequately documented, as follows. In eight cases, the application was incomplete in that the signature of the agent was missing. In two cases, the group contract was not dated. In ten cases involving small groups of under twenty-five employees, no health history form was in the file. In one case, the group contract and schedule of benefits forms was missing. The examiner recommends the Company review and/or implement quality control procedures to ensure all underwriting files be adequately documented by the Company. **(UNDERWRITING/RATING)**

12. In seven cases, the Company failed to retain a signed statement from the small employer that the Company offered to accept all eligible employees and their dependents at the same level of benefits under the health benefit plan provided to the employer. Failure to retain a statement to that effect is a violation of U.A.C. Subsection R590-176-5.A.1. The examiner recommends the Company review and/or implement quality control procedures to ensure compliance with this rule. **(UNDERWRITING/RATING)**

13. A review was performed on fifty-one small employer group applications declined by the Company during 1996 to determine whether the Company was in compliance with U.C.A. Chapter 31A-30, and U.A.C. Rule R590-176. Three of the applications declined by the Company, prior to submitting its June 19, 1996 certification to the commissioner that the Company's open enrollment cap had been met, were eligible for open enrollment under the Rule. Declining open enrollment prior to submitting certification to the commissioner that the open enrollment cap had been met was a violation of U.A.C. Subsection R590-176-8.A. By declining the applications, the Company selectively or unfairly delayed, obstructed or otherwise hindered the applicants from obtaining coverage under U.C.A. Chapter 31A-30. This was a violation of U.A.C. Subsection R590-176-4.A and U.C.A. Subsection 31A-30-108(1). The examiner recommends the Company review and/or implement quality control procedures to ensure compliance with U.C.A. Chapter 31A-30 and U.A.C. Rule R590-176. **(UNDERWRITING/RATING)**

14. U.A.C. Subsection R590-89-10(A), requires acknowledgment of claims not settled within fifteen days of receiving notification of the claim. At least sixteen of the claims reviewed did not meet this requirement. The examiner recommends the Company review and/or implement quality control procedures to ensure compliance with this acknowledgment requirement. **(CLAIMS)**

15. The Company did not prepare certified annual reports of the effectiveness of the organization's internal quality control, as required by U.C.A. Chapter 31A-8. The Company was informed of this requirement in its prior market conduct examination report as of August 31, 1992 by the Utah Insurance Department. Although the format for the report has not been specified by the Insurance Commissioner, lack of a prescribed format does not negate the organization's requirement to prepare the report. Failure to prepare the annual reports is a violation of U.C.A. Section 31A-8-404. The examiner recommends the Company prepare the required report each year, using a format the Company deems best, and submit the report to the appropriate authority. **(HMO SPECIFIC REQUIREMENTS)**

16. The Company has developed a quality assurance plan, however the plan has not been certified, as required by U.A.C. Rule R590-76. The Company was informed of this requirement in its prior market conduct examination report as of August 31, 1992 by the Utah Insurance Department. Failure to arrange and pay for a review and certification of its quality assurance plan is a violation of U.A.C. Subsection R590-76-10.B.1. The examiner recommends the Company arrange and pay for such review and certification as required by this rule. **(HMO SPECIFIC REQUIREMENTS)**

17. Several provider contract files had missing or incomplete documentation. In four cases, the files had signed and dated appendums but no signed provider contracts. In two cases, the execution date of the provider contract was not completed by provider. Five provider contract files did not contain evidence of professional liability insurance for the providers, as required by U.A.C. Rule R590-76, although the Company was informed of this requirement in its prior market conduct examination report as of August 31, 1992 by the Utah Insurance Department. Failure to show evidence of professional liability insurance is violation of U.A.C. Subsection R590-76-12 (F). The examiner recommends procedures be implemented or changed to ensure that the provider contract files contain accurate and complete documentation, including the required evidence of professional liability insurance. **(HMO SPECIFIC REQUIREMENTS)**

18. Company policies and procedures manuals were requested with regard to the areas reviewed during the examination process. Policies and procedures manuals were not in place for producer relationships (licensing, contracting and appointments), or for filing of forms. The examiner recommends the Company has policies and procedures manuals for all areas of Company operations. **(PRODUCER RELATIONSHIPS, UNDERWRITING/RATING)**

### **Examiner's Comments Reference Policyholder Treatment**

Except as noted in this report, policyholders appear to have been treated correctly and fairly by the Company. Underwriting practices appear to be in accordance with those generally in use throughout the industry. Claims appear to be investigated promptly and paid as soon as proper documentation is received from the claimant. Recorded complaints appear and to have been researched and responded to in a timely manner. Company operations also appear to be consistent with public interest.

### **ACKNOWLEDGMENT**

The cooperation and assistance rendered by the officers and employees of the Company during this examination is hereby acknowledged and appreciated.

In addition to the undersigned, Brian W. Hansen, FLMI, CFE, Market Conduct Examiner, assisted in the examination.



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